U.S. Department of Labor Employment Standards Administration

Office of Workers' Compensation Programs



a. Name of Employee Last First Middle DMB No. 1215-0103 b. Mailling Address (Including City State, ZIP Code) C. OWCP File Number d. Date of Injury Month Day Year d. Date of Injury Month Day Year J. Telephone No./FAX No. From Indusive Date Range Intermittent, complete Section 3 Intermittent, complete Form CA-7b. C. Other wage loss: specify type, and have you worked outside your federal job during the period(s) claimed in Section 3, and Complete Form CA-7b. C. Intermittent, complete Form CA-7a, Intermittent, complete Form CA-7b, Intermittent, complete Form CA-7a, Intermitten	SECTION 1		E	MPLOYEE PO	ORTION				
b. Mailing Address (Including City State, ZIP Code) C. OWCP File Number	a. Name of Emp	loyee Las	st	First		Middle	_		
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E-Mail Address (Optional) SECTION 2 Compensation is claimed for From Lave Bale Range From Lave Without pay	b. Mailing Addres	ss (menaing Cit	y State, ZIP Code)				C. OVVCI	i ile ivaiiii	bei
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SECTION 2 Compensation is claimed for:	E-Mail Address ((Optional)			——— Mor	nth Day Year	1		
Leave without pay Leave without pay Leave without pay Leave without pay Leave buy back Yes No Go to Section 3, and Complete Form CA-7b Yes No Go to Section 3, and Complete Form CA-7b Yes No Go to Section 3, and Complete Form CA-7b Yes No Go to Section 3, and Complete Form CA-7b Yes No Go to Section 3, and Complete Form CA-7b Yes No Go to Section 3 Yinter of Section 4 Yes No Go to Section 4 Yes No Go to Section 4 Yes Yes No Go to Section 3 Yinter of Yes							f. Teleph	 one No./F	LL AX No.
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C. Other wage loss: specify type. Such as downgrade, loss of injoht differential, etc. If intermittent, complete Form CA-7a, displicit differential, etc. If intermittent, complete Form CA-7a, displicit differential, etc. If intermittent, complete Form CA-7a, displicit dis								omnlete F	Form CA-7h
such as downgrade, loss of night differential, etc. d Schedule Award (Go to Section 4) SECTION 3 Have you worked outside your federal job during the period(s) claimed in Section 2? (Include salaried, self-employed, commission, volunteer, etc.) Yes Name and Address of Business: No Dates Worked:	_	-	type,		= =			omplete i	OIIII OA-115
d. Schedule Award (<i>Go to Section 4</i>) SECTION 3: Have you worked outside your federal job during the period(s) claimed in Section 2? (Include salaried, self-employed, commission, volunteer, etc.) Yes	such as c	downgrade, loss	of _		If intermitten	t. complete Form	CA-7a.		
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Dates Worked: Type of Work:	∐ Yes N	lame and Addres	ss of Business:						
Dates Worked: Type of Work:		lame		Address			City	State	ZIP Code
SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury? Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up" Has there been any change in your dependents, or has your direct deposit information changed, or has there been a claim filed with U.S. Civil Service Retitement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim? Yes - Complete Sections 5 through 7 or a new SF-1199A to reflect change(s) No - Complete Section 7 SECTION 5 List your dependents (including spouse): Name Social Security # Date of Birth I living with you? Social Security # Date of Birth I Relationship Yes No If Yes, support payments are made to: Name Address City State ZIP Code b. Were support payments ordered by a court? Yes No Have you ever applied for or received disability benefits from the Department of Veterans Affairs? Yes Claim Number Full Address of VA Office Where Claim Filed No Later Yes Claim Number Date Annuity Began Amount of Monthly Payment Retirement System (CSRS, FERS, SSA, Other) SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a felony conviction will result in termination of all current and future FECA benefits.	Go to	N=4== \\\/_== -== -				T 6 \ \ \ /	•		
Yes Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"			7 claim for compananti	on you have fil	lad for this init				
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SECTION 5 List your dependents (including spouse): Name Social Security # Date of Birth Relationship Yes No For dependents not living with you, complete items a and b below. a. Are you making support payments for a dependent shown above? Yes No If Yes, support payments are made to: Name Address City State ZIP Code b. Were support payments ordered by a court? Yes No If Yes, attach copy of court order. SECTION 6 a. Was/Will there be a claim made against a 3rd party? Yes No b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs? Yes Claim Number Full Address of VA Office Where Claim Filed Nature of Disability and Monthly Payment No c. Have you applied for or received payment under any Federal Retirement or Disability law? Yes Claim Number Date Annuity Began Amount of Monthly Payment Retirement System (CSRS, FERS, SSA, Other) CSRS FERS SSA Other SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief. Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation as provided by the FECA, or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a felony conviction will result in termination of all current and future FECA benefits.	☐ fil	led with U.S. Civ	ril Service Retirement, ar	nother federal	retirement or	disability law, or v	vith the Dep	artment of	Veterans
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Employee's Signature Date (Mo_day_vear)	compensation as administrative re	s provided by the medies as well a	e FECA, or who knowing as felony criminal prosec	lly accepts con cution and ma	npensation to y, under appro	which that person opriate criminal p	n is not entit rovisions, be	led is subj e punished	ject to civil or
	Employee's Sign	ature				_ Date (Mo day	v. vear)		

Employing Agency Portion For first CA-7 claim sent, complete sections 8 through 15. For subsequent claims, complete sections 12 through 15 only.

SECTION 8 Show Pay Rate as of	Additional Pay		Additional Pay			Additional Pay			
Date of Injury: Base Pay	Type	Type _	Type			Туре			
Date: /	_ \$ per	_	per	\$_		. pe	r		
Grade: Step:									
Date Employee Stopped Work:	Туре	Type _			Туре				
Date:/ \$ per				- 1		ре	r		
Grade: Step:									
Additional pay types include, but are not limited to: N	ight Differential (ND), Sund	lay Premium (S	P), Holida	ay Premi	um (H	P), S	ubsis	ten	
SUB), Quarter (QTR), etc. (List each separately)									
SECTION 9 a. Does employee work a fixed 40-hour per week sc	hedule? v 🖂 v 🖂	ı							
		•							
 If Yes, circle scheduled days: If No, show scheduled hours for the two week pages 	M T W TH		a day that	work etc	nnad				
FOR EXAMPLE ONLY	ay pendu in which work sto	pped. Circle trie	a uay ina	WOIK SIC	pped	•			
S M T W TH	I F S		S	МТ	Ι ν ν/	TH	F	S	
WEEK 1	WEEK 1			101				<u> </u>	
From 5/14 to 5/20 8 4 6 6) From	to							
NEEK 8 6 6	WEEK 2								
From 5/21 to 5/27 8 6 6	4 From	to							
. Did employee work in position for 11 months prior	to injury?	□No							
No, would position have afforded employment for 1	<i>, ,</i> —		П						
ECTION 10 On date pay stopped, was employee									
	enrolled III. p c. Optional Use Ir	۰ 🗆	N = V	01					
		NCHRANCA' I I							
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-_____ Fax No. (____) E-Mail Address_____

Telephone No. ()

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not quality for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R.10.106.

EMPLOYEE (or person acting on the employee's behalf) – Complete sections 1 through 7 as directed and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) — Complete sections 8 through 15 as directed and promptly forward the form OWCP.

EXPLANATIONS – Some of the items on the form which may require further clarification are explained below:

Section Number	Explanation				
2d. Schedule Award	Schedule awards are paid for permanent impairment to a member or function of the body.				
5. List your dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he, or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-lime student; or 3) is incapable of self-support due to physical or mental disability.				
6a. Was/will there be a claim made against 3rd party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.				
8. Additional Pay	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. It the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.				
11. Continuation of pay (COP) received	If the injury was not a traumatic injury reported on Form CA-1, this item does not apply.				
14. Remarks	This space is used to provide relevant information which is not present elsewhere on the form.				

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 13 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.